DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

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F 000	INITIAL COMMENTS An onsite investigation was conducted related to complaints #29037, #29362 and #29777, during the annual recertification survey on May 29-31, 2012, at Huntsville Manor. No deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to revise the Care Plan for code status for five residents	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla Buttram	Administrator	6/15/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 (#6, #15, #7, #9 and #14) and failed to revise the Care Plan for catheter status for one resident (#5) of eighteen residents reviewed. The findings included: Resident #6 was readmitted to the facility on December 26, 2011, with diagnoses including Cerebrovascular Accident (Stroke), Anemia (Low Red Blood Cell Count), GI (Gastrointestinal) Bleed, Cardiomegaly (Enlarged Heart), Chronic (Long-Lasting) Renal (Kidney) Disease, Aphasia (Impaired Speaking), PEG Tube, Upper Respiratory Distress (Trouble Breathing), and Diabetes Mellitus (High Blood Sugar) Type II. Medical record review of the Physician's Order for Scope of Treatment (POST), dated December 26, 2011, revealed the resident was a Do Not Resuscitate (DNR). Review of the facility's policy, Resident Rights-Advance Directives, not dated, revealed "...advance directives...documented in the...plan of care..." Further medical record review of the IDT (Interdisciplinary Team) Care Plan dated August 11, 2011, revealed the Care Plan had a black line marked through the DNR status. Interview with the Minimum Data Set Coordinator, on May 30, 2012, at 1:45 p.m., at the nursing station, confirmed a black line drawn through the DNR status on the Care Plan updated February 2, 2012, and it was required the code status be updated on the care plan.	F 280	F280 483.20(d)(3) Right to Participate Planning Care-Revise CP Corrective action(s) accomplished for those residents found to have been affected by the deficient practice; 1. The care plan for the code status for resident #6, #15, #7, #9 and #14 currently reflect the facility policy as of May 30, 2012. Care plan has been updated, as well as the current diagnosis for resident #5 on May 29, 2012. Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken; 2. 100% facility audit to be completed by the MDS Coordinator and the MDS Assistant Coordinator of care plans to ensure code status reflects the facility policy. Completion date: June 29, 2012 Measures/systematic changes put in place to ensure that the deficient practice does not recur; 3. In-service conducted by the Administrator with the Management Team on "Daily SWOT Process", and "Follow-up Facility Update Procedures".	

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F 280	Continued From page 2 Interviews with the Director of Nursing and the Corporate Clinical Coordinator, on May 30, 2012, at 1:58 p.m., in the nursing station, confirmed the facility failed to update the code status on the Care Plan per facility policy. Resident #15 was admitted to the facility on August 15, 2012, with diagnoses including Urinary Tract Infection, Gastrointestinal Hemorrhoids, Osteoporosis, Anemia, Hypothyroidism, and Syncope. Medical record review of the POST form, dated May 28, 2012, revealed "...Do Not Resuscitate (DNR)..." Medical review of the Care Plan dated January 4, 2012, revealed no documentation of the DNR status. Interview with the Administrator on May 30, 2012, at 3:45 p.m., in the nurse's station, confirmed the DNR status was not documented on the resident's care plan. Resident #7 was admitted to the facility on March 28, 2011, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Cardiomegaly, and Breast Cancer. Medical record review of a signed POST dated March 15, 2012, revealed "...Do Not Attempt Resuscitate..." Medical record review of a Care Plan dated August 11, 2011, and last reviewed on May 21,	F 280	Completion date: June 15, 2012 4. Director of Nursing will assure compliance by: Audit of 4 residents per week for 4 weeks to ensure that a comprehensive care plan has been developed within 7 days after the completion of the comprehensive assessment to reflect any resident with a change in diagnosis, code status, and/or indwelling catheter. Overall findings will be reported to the Administrator immediately when policy is not adhered to. Violation of facility policy will result in disciplinary action in accordance with facility progressive discipline policy. Report of overall findings and subsequent disciplinary action, if applicable will be reported to the facility QA Committee (DON, ADON, NHA, Risk Manager, Social Service Director, Nurse, Medical Director, Pharmacy Consultant) to review of need for continuation or amendment to the plan. 5. Completion Date: 7/15/12	7/15/12

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F 280	Continued From page 3 2012, revealed the Do Not Resuscitate (DNR) status was deleted from the care plan. Resident #9 was admitted to the facility on May 2, 2008, for diagnoses including Dysphagia, Renal Failure, Alzheimer's Disease, and Osteoarthritis. Medical record review of a signed POST form dated February 22, 2011, revealed "...Do Not Attempt Resuscitate..." Medical record review of a Care Plan dated May 10, 2011, and last reviewed on May 4, 2012, revealed the DNR status was deleted from the care plan. Resident #14 was admitted to the facility on May 9, 2011, with diagnoses including Alzheimer's Disease, Encephalopathy, Thrombocytopenia, and Osteoarthritis. Medical record review of a signed POST form dated January 16, 2012, revealed "...Do Not Attempt Resuscitate..." Medical record review of a Care Plan dated September 14, 2010, and last reviewed on March 1, 2012, revealed the DNR status was deleted from the care plan. Interview with the Corporate Clinical Consultant on May 30, 2012, at 1:40 p.m., at the Nurses' Station, confirmed the DNR status was to be on the care plans and the facility was not following facility policy. Resident #5 was admitted to the facility on	F 280		

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F 280	Continued From page 4 February 2, 2012, with diagnoses including Anemia, Cirrhosis, Encephalopathy, Ascites, Gastritis, Malnutrition, Delirium Tremens (Alcohol Withdrawal), Hyponatremia, and Unsteady Gait. Observation on May 29, 2012, at 12:55 p.m., in the resident's room, revealed the resident up in the chair with a urinary catheter draining to a privacy bedside bag. Medical record review of the nurse's notes revealed the resident was sent to the hospital on February 5, 2012, and returned on February 11, 2012, with an indwelling urinary catheter and a new diagnosis of Neurogenic Bladder and inability to void. Medical record review of the care plan dated February 14, 2012, revealed the catheter had not been addressed since the resident had returned from the hospital. Review of the facility's policy Care Planning - Goals and Objectives, revised January 2002, revealed "...Goals and objectives are reviewed and/or revised...significant change in the resident's condition...when the resident has been readmitted to the facility from a hospital/rehabilitation stay..." Interview on May 30, 2012, at 9:50 a.m., in the conference room, with the Director of Nursing (DON) confirmed the care plan had not been revised following the hospital stay to accurately reflect the resident's new diagnosis and need for an indwelling urinary catheter or care of the catheter.	F 280		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		

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F 328 SS=D	Continued From page 5 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure proper treatment for a resident with continuous tube feedings and a tracheostomy stoma (old surgical site used to maintain the airway) for one resident (#3) of eighteen residents reviewed. The findings included: Resident #3 was admitted to the facility on April 20, 2010, and readmitted to the facility on February 7, 2012, with diagnoses including Anoxic Brain Injury, CVA (stroke), Aspiration, Bacterial Pneumonia, Hypertension, Diabetes Mellitus, and Gastrostomy Tube Feedings. Review of the Minimum Data Set dated March 31, 2012, revealed the resident was severely cognitively impaired and dependent for all activities of daily living.	F 328	F328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice;** 1. Resident #3 was repositioned and cleaned on May 29, 2012 at 1:17 pm by the charge nurse. Completion date: 5/29/12 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. Guardian Rounds was conducted on May 30, 2012 by MDS Coordinator to ensure that all residents with a feeding tube were positioned at a 45 degree angle and proper cleaning and care conducted. **Measure/systematic changes put in place to ensure the deficient practice does not recur:** 3. In-service conducted by the Risk Manager of all Department Managers, nursing, and therapy staff on "Positioning of Tube Feeding Patients" and "Guardian Rounds". Completion date: June 29, 2012 Guardian Rounds conducted daily by department managers to ensure proper positioning and cleaning of tube feeding patients. Designated department manager to monitor and assess the care of tube feeding residents daily in accordance with "SWOT Process"	

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F 328	Continued From page 6 Observation on May 29, 2012, from 12:43 p.m. to 1:17 p.m., revealed the resident was lying supine (flat on back) on the bed. Continued observation revealed the head portion of the bed was raised at a 45 degree angle and the resident had slid downward toward the foot of the bed. Continued observation revealed the resident's head was lying flat on the bed. Continued observation revealed the resident was recieving a tube feeding via the gastrostomy tube. Continued observation revealed the resident with an open stoma (a surgical puncture hole) in the midline (center) of the throat at the site of a previous tracheotomy (old surgical site to maintain the airway). Continued observation revealed green sputum oozing from the stoma onto the resident's neck. Continued observation revealed the resident breathing through the nose with supplemental oxygen in place and intermittently coughing, causing the sputum to bubble and drain onto the resident's neck and chest. Observation at 1:13 p.m., revealed a Certified Nurse Aid (CNA) exited the room directly beside the resident's room, stopped at the resident's doorway, looked inside the resident's room, and proceeded down the hallway away from the resident's room. Continued observation at 1:16 p.m., revealed a Licensed Practical Nurse (LPN) entered the resident's room and summoned a second LPN to the room at 1:17 p.m., at which time the resident was repositioned, and the sputum wiped from the neck. Review of the Physicians Recapitulation Orders dated May 1, 2012, revealed, "...head of bed at	F 328	**Monitoring of corrective action to ensure the deficient practice will not recur:** 4. MDS Coordinator will assure compliance by monitoring for 4 weeks to ensure that tube feeding residents positioned at 45 degree angle and proper care and cleaning has been conducted and will be reported to the Qaulity Assurrance Committee. Overall findings will be reported to NHA immediately when facility policy and procedure is not followed. Failure to adhere to the proper position, care and cleaning of tube feeding resident will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of Medical Director, Pharmacy Consultant, Central Supply Clerk, Wound Care Nurse, DON, ADON, SSD, NHA, Risk Manager, MDSC, Nurse, and Housekeeping Supervisor) to review the need for continued intervention or amendment of plan. 5. Completion date: July 15, 2012	7/15/12

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F 328	Continued From page 7 45 degree angle..." Interview with LPN #5 on May 12, 2012, at 1:20 p.m., inside the resident's room, confirmed the resident's head was not elevated at a forty- five degree angle as required while receiving continuous tube feedings, confirmed the resident's stoma was in need of cleaning and care, and confirmed the resident had not received proper care for a resident with continuous tube feeding and a stoma.	F 328	F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS **Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:** 1. Licensed nurse #2 for 200/300 hall was in-serviced on "Storage of Medications" policy, disciplinary action in accordance with facility policy, and given a performance improvement plan by the Director of Nursing. Completion date: June 20, 2012	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	All medications labeled and external and internal meds separated in accordance with regulations for the 200 and 300 med carts. Completion date: May 31, 2012 **Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken:** 2. Risk Manager in-serviced all licensed staff on "Storage of Medication" policy. Completion date: June 29, 2012 **Measures/systematic changes put in place to ensure that the deficient practice does not recur:** 3. NHA in-serviced with DON, Risk Manager, Assistant Director of Nursing (ADON), and Minimum Data Set Coordinator (MDSC) on facility "Storage of Medication" policy. Completion date: June 20, 2012 "Storage of Medications" policy has been added to new employee orientation for all licensed staff. Completion date: June 1, 2012 (ongoing)	

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F 431	Continued From page 8 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label medications with the resident's name, and failed to separate internal and external medications on two of four medication carts observed. The findings included: Observation on May 31, 2012, at 11:40 a.m., in the 200 hallway, of the 200 hallway medication cart, revealed an opened box of Monistat 7 vaginal cream and suppositories not labeled with a resident's name. The box of Monistat was stored next to an open box of Lovenox (blood thinner) 80 mg (milligram) injectable syringes in drawer #6. Interview on May 31, 2012, at 11:45 a.m., in the 200 hallway, with Licensed Practical Nurse (LPN) #2, confirmed the medication was not labeled with a resident's name and injectable medications were not to be stored with external medications or ointments. Observation on May 31, 2012, at 11:50 a.m., at the nurse's station, of the 300 hallway medication	F 431	Med Cart Observation Audits will be conducted by the DON (or ADON in absence of DON) 5 times per week for 4 weeks to ensure "Storage of Medication Policy is being adhered to. **Monitoring of corrective action to ensure the deficient practice will not recur:** Risk Manager will conduct 3 med cart observation audits per week over the next 4 weeks to ensure "Storage of Medication Policy is being adhered to. Overall findings will be reported to the NHA immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive disciplinary policy. Report of overall findings and subsequent disciplinary actions, if applicable, will be reported to the facility Quality Assurance (QA) Committee (consisting of Medical Director, Pharmacy Consultant, Dietician, Psychologist, Central Supply Clerk, Wound Care Nurse, DON, ADON, SSD, NHA, Risk Manager, MDSC, Restorative and/or C.N.A., Maintenance Supervisor, and Housekeeping Supervisor) to review the need for continued intervention or amendment to the plan. 5. Completion date: July 15, 2012	7/15/12

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F 431	Continued From page 9 cart, revealed an opened tube of Triamcinalone Cream (steroid) not labeled with a resident's name. The tube of cream was stored next to syringes filled with normal saline (used for flushing intravenous line) and vials of normal saline in drawer #6. Interview on May 31, 2012, at 11:55 a.m., at the nurses's station, with LPN #2, confirmed the medication was not labeled with a resident's name and injectable medications were not to be stored with external medications or ointments.	F 431	F508 483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS Corrective action(s) accomplished for the residents found to have been affected by the deficient practice; 1. Resident #2's chest xray was obtained on June 1, 2012 and family was notified of the results. Completion date: June 1, 2012	
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow a Physician's Order for a Chest X-Ray for one (#2) of eighteen residents reviewed. The findings included: Resident #2 was admitted to the facility on May 11, 2012, with diagnoses including Acute Kidney Disease, Cerebrovascular Accident, Anemia, Depression, Dementia, and Anxiety. Medical record review of the Minimum Data Set dated May 6, 2012, revealed the resident required extensive assistance with decision making, had	F 508	Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken: 2. 100% audit of resident charts, physician orders, and lab book conducted by Medical Records to verify all labs have been obtained for all orders. Completion date: June 29, 2012 Measures/systematic changes put in place to ensure that the deficient practice does not recur; 3. In-service conducted by Risk Manager with licensed staff and Medical Records on "Obtaining Labs and family notification of results". Completion date: June 29, 2012 Medical Record review conducted in regular morning meeting to verify labs obtained in accordance with physician orders.	

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F 508	Continued From page 10 short and long term memory problems, and required extensive assistance with transfers and all activities of daily living. Medical record review of a Physician Order dated February 28, 2012, revealed, "...CXR (Chest X-Ray)..." Observation and interview on May 31, 2012, at 9:00 a.m., in the resident's room, revealed the resident sitting on the side of the bed. The resident was very confused and agitated. The resident's daughter was present. Interview with the daughter revealed the resident had refused all medications and had refused to eat breakfast. Continued interview revealed the facility had not informed the resident's family of the results from the chest x-ray. Medical record review revealed no documentation the chest x-ray had been obtained. Interview with Registered Nurse #1 on May 31, 2012, at 9:30 a.m., at the nursing station, confirmed the facility failed to obtain the chest x-ray as needed.	F 508	Monitoring of corrective action to ensure the deficient practice will not recur; 4. NHA will assure compliance by: 5 resident charts per week for 4 weeks will be audited for accurance of labs obtained and notification of results to family noted.. Results will be provided to the Quality Assurrance Committee. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive policy. Report of overall findings and subsequent disciplinary action, if applicable will be reported to the facility QA Committee (DON, ADON, NHA, Risk Manager, Charge Nurse, Medical Director, Pharmacy Consultant, Dietician, SSD, and Wound Care Nurse) for further monitoring. 5. Completion date: July 15, 2012	7/15/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. BUILDING _____ B. WING _____	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

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F 514	Continued From page 11 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure accurate documentation of the Do Not Resuscitate order for three residents (#7, #14, and #6) of eighteen residents reviewed. The findings included: Resident #7 was admitted to the facility on March 28, 2011, with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Cardiomegaly, and Breast Cancer. Medical record review of a signed Physician Orders for Scope of Treatment (POST) dated March 15, 2012, revealed "...Do Not Attempt Resuscitate..." Medical record review of a Physician's Recapitulation Order Sheet for May 2012, revealed "...code status...full code..." Interview with the Administrator on May 30, 2012, at 1:40 p.m., at the Nurses' Station, confirmed the resident was a Do Not Resuscitate (DNR) and the Physician's Recapitulation Order Sheet was incorrect. Resident #14 was admitted to the facility on May 9, 2011, with diagnoses including Alzheimer's	F 514	F514 483.75(l)(1) RES Records - Complete/Accurate/Accessible Corrective action(s) accomplished for the residents found to have been affected by the deficient practice; 1. Resident #7, #14, and #6's clinical record contains accurate documentation and sufficient information to identify the resident's code status. Completion date: May 30, 2012 Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken: 2. 100% audit of resident medical records completed by Medical Records and MDS Coordinator to reflectaccurate documentation and sufficient information to identify the resident's code status. Completion date: June 29, 2012 Measures/systematic changes put in place to ensure that the deficient practice does not recur; 3. In-service conducted by NHA with Medical Records, MDS Coordinator, Director of Nursing, and nursing staff on "Complete and Accurate Clinical Records". Completion date: June 29, 2012	

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F 514	Continued From page 12 Disease, Encephalopathy, Thrombocytopenia, and Osteoarthritis. Medical record review of a signed POST form dated January 16, 2012, revealed "...Do Not Attempt Resuscitate..." Medical record review of a Medication Administration Record (MAR) dated May 1, 2012 through May 31, 2012, revealed "...code status...full code..." Interview with the Director of Nursing (DON) on May 31, 2012, at 8:47 a.m., in the DON office, confirmed the resident was a DNR and the MAR was incorrect. Resident #6 was readmitted to the facility on December 26, 2011, with diagnoses including Cerebrovascular Accident (Stroke), Anemia (Low Red Blood Cell Count), GI (Gastrointestinal) Bleed, Cardiomegaly (Enlarged Heart), Chronic (Long-Lasting Renal (Kidney) Disease, Upper Respiratory Distress (Trouble Breathing), and Diabetes Mellitus (High Blood Sugar) Type II. Medical record review revealed no POST on the resident's chart. There was a DNR sticker on the inside of the chart and a Physician's Order, dated May 2, 2012, for "Code Status...Full Code". Interview with the DON on May 29, 2012, at 3:40 p.m., in the conference room, confirmed there was no POST on the resident's chart, a sticker inside the chart indicated the resident was a DNR, and a Physician's Order, dated May 2, 2012, indicated "Code Status...Full Code..."	F 514	Medical Record review conducted in regular morning meeting verifying accurate and sufficient documentation is in place to identify the resident's code status.. Monitoring of corrective action to ensure the deficient practice will not recur; 4. DON will assure compliance by: 5 resident charts per week for 4 weeks will be audited for accurate documentation and sufficient information to identify the resident's code status. Results will be provided to the Quality Assurance Committee. Overall findings will be reported to the Administrator immediately when policy is not adhered to. Failure to adhere to facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility progressive policy.	

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F 514	Continued From page 13 Interview with the DON on May 29, 2012, at 3:45 p.m., in the conference room, confirmed the code status of the Physician's Order and POST did not match. Interview with the Administrator on May 29, 2012, at 3:51 p.m., at the nursing station, confirmed there was no POST in the resident's chart but was located in the Administrator's office indicating the resident was a DNR, and the medical record was not accurate.	F 514	Report of overall findings and subsequent disciplinary action, if applicable will be reported to the facility QA Committee (DON, ADON, NHA, Risk Manager, Charge Nurse, Medical Director, Pharmacy Consultant, Dietician, SSD, and Wound Care Nurse) for further monitoring. 5. Completion date: July 15, 2012	7/15/12